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AUTHOR Hooyman, Nancy R.; Tomita, Sue
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ABSTRACT

This paper describes a model, to be adopted or adapted by human services professionals, for overcoming barriers to the detection, intervention, and prevention of elder abuse. The barriers (professional denial of abuse problems, lack of detection, guidelines and intervention procedures, and the absence of community support services) are identified along with the seven model objectives designed to address these problems. The model's major components, i.e., development of written protocol for detection and assessment, education and training of staff, and identification of appropriate interventions at the individual, family and community level are presented in detail. The four appendices provide specific implementation aids including: (1) outlines for a medical history and psychosocial, physical and caregiver evaluations; (2) a care plan outline (diagnostic, educational, and therapeutic); (3) evaluation forms (Goldfark Dementice Scale, the Elderly Abuse Questionnaire, and the Elder Abuse Study form); and (4) a directory of community agencies with descriptions of services. A reference list is also included. (MCF)

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INTERVENTIONS IN CASES OF ELDERLY ABUSE WITHIN MEDICAL SETTINGS

Presented at an
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Nancy R. Hooyman, Ph.D.
Associate Professor
School of Social Work
University of Washington
Seattle, Washington

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Sue Tomita, MSW
Department of Social Work
Harborview Medical Center
Seattle, Washington

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INTERVENTIONS IN CASES OF ELDERLY ABUSE

Introduction:

Journalistic accounts, Congressional hearings, and numerous proposals for programming and policy changes have all developed in response to societal recognition of the problem of elderly abuse. One common response is the passage of mandatory reporting laws to improve the reporting and recording mechanisms. To pass mandatory reporting laws, however, without at the same time providing necessary community-based services for the older victim and the family does little to solve the problem of abuse. In fact, a recent review of state legislation concluded that while statutes are predicated on the importance of utilizing the least restrictive alternative in treatment and placement, the funding and development of such programs and alternatives are insufficient to realize the premise (Bergmann, et al., 1979). A challenge facing health care professionals is to develop appropriate methods of intervention and prevention to deal with the underlying conditions of abuse, while recognizing the rights of the elderly to choose their own way of life.

Any system to respond to the problem of abuse should include techniques to identify cases of abuse and the capacity for coordinated, interdisciplinary responses. This paper describes one possible model for an integrated and appropriate response to the problem, developed by social services staff, physicians, and nurses within a hospital setting.

Any interventive and preventive effort must first clarify whether the target is the victim, the abuser, the total family system, or all three. At different stages, this model attempts to reach all three populations and incorporates the elements of improved detection and intervention procedures

as well as providing support for the caregivers as a means of prevention. High-risk families and at-risk elderly are identified through a detailed case assessment protocol; both direct and indirect interventions are then implemented at the levels of the victim, the abuser and the community.

The authors present this model in the early stages of its implementation with the hope that other organizations will adapt components to their needs and settings. Feedback on the attached materials is welcome.

Rationale:

The model is based on the assumption that in order for helping professionals to detect, intervene and prevent cases of elderly abuse, three major barriers must be overcome. The first is the denial by helping professionals that the problems of abuse and neglect exist within their own client populations. Such denial can hinder victims' help-seeking efforts. The University of Maryland study found, for example, that most of the victims sought help, but were unsuccessful in obtaining it (1979). Second is the need to develop written procedures for case detection. Few service providers have routine reporting or intervention procedures designed specifically for domestic maltreatment of the elderly. In fact, many practitioners are frustrated when presented with an abuse or neglect case by having no set of specific, appropriate procedures available (Douglas, 1979). The third major barrier is the lack of service and support options for the elderly abused person, the abuser, and the family. Clearly, both victims and helping professionals will be reluctant to acknowledge the problem of elder abuse until they feel viable options exist (Block & Sinnott, 1979; Douglas, 1979).

Purpose of the Model:

The primary purpose of this model is to begin to address these barriers to the detection, intervention, and prevention of elder abuse: 1) human service professionals' denial of the phenomenon of elder abuse amongst their own client population, 2) the lack of case detection guidelines and intervention procedures, and 3) the absence of community support services for both victims of abuse and their families. The following objectives have been identified:

1. To increase helping professionals' awareness and understanding of the phenomenon of elder abuse through the development of training materials and the utilization of educational workshops.
2. To improve helping professionals' detection, assessment, and documentation of both abusive and high-risk families through the use of a written protocol for case detection.
3. To develop appropriate interventions for victims of abuse.
4. To develop and implement peer support and informational groups for high-risk families with older relatives.
5. To coordinate efforts by relevant community agencies (e.g., the Area Agency, Adult Protective Services) to maximize existing resources.
6. To collect data on the characteristics of the abused, the abusers, and of the family systems.
7. To evaluate the effectiveness of training in increasing helping professionals' awareness and knowledge of elder abuse.

Interventive Settings:

The sites for implementation of the model are the Emergency Room and the Senior Care Program of Harborview Medical Center, a large teaching hospital affiliated with the University of Washington, Seattle, Washington. As the region's Trauma Center, Harborview deals not only with the traditional medical and multiple systems physical trauma, but also with major psychosocial trauma as well: suicide attempts, alcohol abuse, battered women, and other forms of victimization. Twenty-seven percent of the population seen in the Emergency Room are elderly. At least one case of abuse or neglect is seen daily in the Emergency Room. The Social Work Department of Harborview, with a staff of 60, is nationally recognized for its pioneering work in family violence.

The Harborview Senior Care Program (HSCP) is an interdisciplinary model project at Harborview sponsored by the Long-Term Care Gerontological Center at the University of Washington. The program integrates health and social services for older persons with acute and chronic illnesses. The goal is to maximize independent functioning of the frail elderly by providing a continuum of care to meet the individuals' needs at the appropriate level. The program consists of: 1) a small inpatient unit offering assessment and rehabilitation services to older persons with some acute illness, 2) an outpatient clinic providing assessment and continuing followup for older adults with complex social and medical problems, 3) a consultation service assisting other services and disciplines in the hospital with questions relating to the management of complex problems confronting the elderly and their care, and 4) nursing home followup services in which physicians follow designated patients in three local nursing homes.

Since the Senior Care Program follows the patient and works closely with families from the point of crisis to outpatient care to nursing home care and provides long-term followup, staff have numerous occasions to diagnose and treat high-risk situations. The Senior Care physicians fully support efforts to detect and prevent abuse; a 1981 survey of physicians, however, indicated that the majority of them did not have a clear definition of abuse, did not systematically look for signs that might indicate abuse, and did not followup on suspicious cases. Until a 1980 in-service presentation to social workers on the phenomena of elderly abuse, most social services staff had not thought about the problem.

A primary factor in this model's success has been that one social worker has taken a lead role in educating staff about elderly abuse. In addition, because this hospital has a history of dealing with issues of family violence, both administrative and medical staff have been supportive of the social worker's efforts and have agreed that an organizational priority is the training of staff regarding elder abuse.

The major components of the model are development of a written protocol for detection and assessment, training of medical and social services staff, and identification of appropriate interventions at the individual, family and community levels.

Written Protocol for Identification and Assessment:

A case identification and assessment protocol, developed in consultation with physicians from Internal Medicine and the Emergency Room, is being implemented in both the Emergency Room and Senior Care Program (see Appendix for copy of protocol). After developing the protocol, the next step has been to train physicians and social services staff regarding its use.

Because Harborview already has other protocols for alcoholism and spouse and child abuse, staff were accustomed to using protocols and receptive to its implementation.

Effective and timely use of the protocol requires that social services staff cultivate referrals throughout the hospital and be available to intervene as soon as possible after the referral is made. Referrals come primarily from: 1) the Emergency Room Chief of Services, who reviews every Emergency Room patient's chart and sends copies of the face sheet and of the Emergency Room exam to the appropriate social services staff when he suspects abuse; 2) the inpatient social work staff, who are oftentimes aware of patients' reluctance to return home or seem fearful around their families; and 3) hearsay during "informal" discussions with other staff. For example, nursing staff are particularly likely to observe behavior suggesting abuse, such as the patient's screaming "don't hit me" at night and appearing fearful during family visits.

Medical staff, on hearing about this elder abuse project, are able to recall patients in their caseload being abused or neglected. If asked, they are able to relate details of the case and often will refer the case(s) to a social worker when they realize intervention is possible. The social wortker needs to be skilled in developing and maintaining these varied referral sources.

Education and Training of Staff

Training of medical and social services staff occurs both informally and formally. Informal training is patient-specific, taking place whenever a staff member is concerned about abuse of an individual patient. It consists of doing the assessment protocol with the staff member as observer,

suggesting possible interventions, and teaching them how to document suspicious findings. The advantages of informal training are that staff can be helped in a timely manner, they are able to share this difficult situation and responsibilities with someone else (e.g., the trainer) and immediate follow-up is possible.

Formal training aims to increase staffs' awareness of elderly abuse/-neglect; reduce staff denial of the possibility of abuse among their own elderly population; increase staffs' detection, assessment and intervention skills; and enhance staffs' recognition that victims of abuse can benefit from the interventions (e.g., that staff involvement in elderly abuse cases is not necessarily a negative experience and that cases can be satisfactorily resolved).

Within this medical setting, the major forum for formal training has been rounds. There are a variety of rounds: chart rounds; interdisciplinary team rounds held on each floor to discuss each patient's diagnosis and treatment plan; and grand rounds held by each discipline, such as social work, nursing, surgery, neurology, geriatric, primary care, and internal medicine. Training is also offered at the monthly orientation sessions of medical residents who rotate through the Emergency Room on a monthly basis.

The packet of training materials includes:

a. Definitions of elder abuse/neglect

b. Prevalence and characteristics of elder abuse/neglect, based on national and local studies.

c. Possible explanations of abuse

d. Copies of the protocol and guidelines for using it

e. Possible interventions

f. A reading list

A staff member who has treated a victim of abuse presents how they have used the training materials as well as their own personal reactions to the problem of elderly abuse. Future training will include slide and videotape presentations of victims being diagnosed and treated by staff.

Prior to the training, participants are asked to complete a brief questionnaire to assess their knowledge about abuse (see Appendix). This questionnaire will also be administered six weeks after training to attempt to assess any changes in participants knowledge about elder abuse and possible interventions.

In addition, an audit is being conducted on all people over 65 seen in the Emergency Room for a one-month period prior to the training of Emergency Room staff and one-month period following the training. Originally, only cases involving dehydration, lacerations, burns, and fractures were to be studied. The criteria for selection were broadened, however, since people over 65 with different diagnoses than the above four may also be victims of abuse/neglect. The criteria for selecting a patient for audit are: 1) the patient is 65 years or older, and 2) the patient has visited the Emergency Room during the period selected for audit. The twelve criteria for chart review are (see Appendix for audit form):

1. Interviewer documented how presenting injury or illness occured. (yes/no)
2. Interval between onset of injury and date of arrival to ER (# of days)
3. Toxicologic screen for drug levels indicate over-medication (yes/no/na)
4. Toxicologic screen for drug levels indicate under-medication (yes/no/na)
5. Documentation of dehydration without illness-related cause (yes/no/na)
6. Documentation of presence of old bruises or hematoma(s) (yes/no)

7. Documentation of presence of new bruises or hematoma(s) (yes/no)

8. Documentation of discrepancy between statement of how injury occured and physical findings (yes/no)

9. Documentation that injury presented to ER is of unknown etiology (yes/no)

10. Interviewer asked patient if being abused or neglected (yes/no/exception*)

11. Interviewer asked informant if patient being abused or neglected (yes/no/na)

12. Documentation of suspicion of elder abuse/neglect (yes/no)

13. Documenting treatment plan for elder abuse/neglect: a) yes, patient referral to ER social worker; b) yes, patient referral to inpatient staff; c) yes, patient referral to community agency; d) yes, resource information and/or education provided; e) other; f) none

*Exception: Patient was unable to respond.

These data will be useful not only for evaluating whether the training has impacted on professionals' behavior when presented with a high-risk situation, but also for documenting the incidence and characteristics of abuse within this setting.

Identifying Appropriate Interventions

Developing appropriate interventions at the level of the individual with victim, the family, and the community is perhaps the most complex task.

Interventions with the victim. Interventions with the individual victim are botn indirect and direct and take place in the emergency room, on an inpatient basis, and on an outpatient basis.

a. Indirect interventions consist of documentation and referral to another agency for follow-up, such as Adult Protective Services. This is often the pattern with emergency room

follow-up, where abuse is suspected and the patient is called or sent a letter asking them whether they need additional assistance since leaving the emergency room. In many cases, referral to other community resources may be most appropriate. The community agency can be asked to "check up" on the patient in their home and to refer back if further intervention is necessary and feasible.

Indirect interventions also are used on an inpatient basis, where the abuse is documented and the assessment protocol administered, but no further actions can be taken, primarily because the victim resists any changes in their situation. In interviewing the victim, it is important to begin with general, nonthreatening statements, such as "Can you describe a typical day at your home for me?", and establish trust, then slowly lead into statements directly related to abuse and neglect, i.e., "Have you ever been shoved, hit, or pushed? By whom?" Oftentimes, several short sessions are necessary to ask all questions in the protocol, especially if the patient has memory problems or is very ill.

Part of the assessment includes documentation in detail in the patients' chart for all staff to read. Findings are explicitly described and quotations used to document the patients' verbatim statements. The patient's trunk and extremities are sketched and bruises, burns, lacerations, etc., are drawn according to size, type, and location to call attention to the seriousness of the problem. Such eye-catching

sketches in the chart can be very important for future reference and interventions.

Nursing staff can be especially helpful during this assessment. For example, a patient with organic brain syndrome may be admitted to the hospital with bruises of unknown etiology. If the staff feel the patient's bruises were due to high bruisability and not abuse, the nursing staff can observe how easily bruisable the patient is. If the patient develops no new bruises from regular handling and/or from wrist or waist restraints (a safety measure used to keep demented patients from wandering or falling out of bed) and if the bruises presented upon admission fade away during the patient's hospital stay, then the patient is more likely viewed as a victim of abuse/neglect.

Intervention occurs on an outpatient clinic basis when the medical staff, suspecting abuse and neglect, refers the case and when the social worker, conducting the standard psychosocial assessment on all new patients in the clinic, suspects abuse/neglect. In contrast to using the protocol on an inpatient basis, less time is available in outpatient settings to detect and treat abuse/neglect. Oftentimes, only documentation of bruises is possible; only after repeated clinic visits can abuse/neglect be confirmed. For these reasons, suspicions of abuse/neglect should be noted in the chart in order to alert medical staff to watch for signs of abuse/neglect in the next clinic visits. A note to the

physician to contact the social worker during the patient's next clinic visit is also advisable.

Since clinic patients are often accompanied by their family caregivers, care must be taken to assure confidentiality and to insist on interviewing the patient and caregiver separately. The caregiver is likely to resist an interview with social services staff; however, if the protocol is introduced as a standard part of the clinic exam and is read by the interviewer, the caregiver may be less defensive and less likely to feel that they are being singled out or unjustly accused of wrongdoing.

b. Direct interventions are feasible when the patient admits the need for help and when there are repeated contacts with the patient. As with indirect interventions, the first step is detailed diagnosis for further assessment and case planning. Additional steps include the development of therapeutic plans, such as: 1) repeated home visits or appointments in the office to gain trust, and to help the elderly with decision making, ventilation, and problem solving; 2) legal interventions, such as guardianship or protective payee status; 3) instruction in techniques of self-care and assertiveness to reduce dependency on caregiver; 4) moving to another living situation, such as share-a-home, adult foster home, boarding home, congregate housing or nursing home; 5) development of increased contacts outside of the home, such as adult day centers; and 6) advocacy and resource linkage, such as assisting the elder with obtaining meals on wheels, chore service or home health care and linking

the elder with natural helpers, such as friends, neighbors, and volunteers. At the discharge of cases involving such interventions, an outpatient clinic appointment should be made with the patient for follow-up of the patient's situation.

Interventions with the Family Caregiver

Since most elder abuse is inflicted by family members, any intervention plan must take into account the structure and functions within the family system. To provide an appropriate match between services and needs, it is essential to complete a family-oriented assessment and utilize the results in setting intervention goals. Psychological, economic, health, and social factors must be considered from the perspective of the victim, abuser, and other family members. Gathering information is best facilitated through multiple interviews and observations, ideally in the home setting. Gathering information about the family prior to finalizing an intervention plan is useful, even if some interventions must be delivered because of crisis circumstances prior to completing a full assessment.

Three types of interventions are used with family caregivers: a therapeutic plan, an educational plan, and resource linkage.

a. The therapeutic plan involves repeated home or office visits with social service staff to evaluate the caregiving person's functional capabilities, clarify role expectations, reduce conflict, and assist families in communication and decision making.

b. The educational plan is closely related to the therapeutic plan, since part of the overall treatment may involve informing caregivers about the aging process and about community resources. In Spring 1982, educational and support groups for family caregivers will be implemented through the

Senior Care Program. A letter will be sent to all relatives of Senior Care patients, informing them of a series of educational meetings and asking them what specific topics they would like covered within broad categories.

Sessions will include content related to physical and psychological aspects of the aging process, chronic illnesses, and behavioral changes with age, sensory deprivation and techniques of communication, decision making in alternative living situations, and availability, utilization, and mobilization of community resources. Throughout the sessions, family members will be encouraged to share their feelings about their caregiving role and will learn techniques for effectively dealing with their own needs and reducing the stress of caregiving. Emotional support of group members is expected to be a valuable product of the educational group experience.

A packet of practical "how to," written materials will be given to family members. Examples of such materials are: a directory of community services to enable older people to remain in their homes; guide for the home care of dementia patients; symptoms of dementia and where to turn for help; memory aides; do's and don'ts of drug use; and home safety lists.

c. Resource linkage may occur as part of the educational plan, but also can be implemented as a separate component. Locating respite care or day care for the elder in order to give family members a rest, obtaining cash grants for the caregiver when possible, and identifying appropriate community resources are ways to relieve the burdens of caregiving on family members.

Interventions in the Community

Since community resources to adequately deal with the problem of abuse are scarce, it is essential that agencies network to combine resources.

Adult Protective Service units, the Area Agency, homemaker services, home health care agencies, and legal services for the elderly are vital actors in such a network.

With the assistance of a volunteer who is a social work professional, networks are being developed among relevant community agencies to form a Council on Elderly Abuse and Neglect, concerned primarily with formulating a coordinated response to elderly abuse. The Council will promote the sharing of resources and the distribution of information about the problem of elder abuse and neglect, the elderly person's rights, and where help can be obtained. For example, an informational brochure on elderly abuse is distributed in the Harborview Emergency Room and in agencies serving older people in an effort to reach both vulnerable elderly as well as friends, neighbors, and other relatives who may be aware of abuse (see Appendix).

This model also includes the training and utilization of community gatekeepers; the gatekeeper approach, however, will not be implemented until all the other components are functioning effectively. Gatekeepers are people in visible "crossroads" positions who have access to valuable resources and interact with the elderly on a regular, predictable basis. They include postal carriers, cab drivers, local merchants, waitresses, bank tellers, pharmacists, and beauticians. Because of their visible positions, they are likely to be turned to for help, to know and keep an eye on others' actions, and to offer emotional support, practical aid, and information. Such gatekeepers could be informed and trained regarding signs of abuse, available services, and reporting procedures. As it is now, gatekeepers may suspect problems such as abuse and neglect, but not know what to do. Such a training effort would require staff with organizational skills and the time to meet with neighborhood groups.

Conclusion

Implementation of this model clearly depends upon administrative commitment and upon health professionals' sensitivity and skills in reaching victims and families. The authors contend, however, that such a model can be implemented in medical settings without a large expenditure of financial resources, since components can be delivered as part of a hospital's existing training, educational, and support functions. After training materials have been developed, they can be disseminated to other hospitals and community-based settings. For example, an elderly abuse protocol can become part of the hospital-wide reporting system. Staff who have been trained regarding elderly abuse can continue to train new staff as part of existing rounds and unit meetings. The value of this model is thus that it integrates detection, intervention, and prevention procedures among a number of health care professionals as part of ongoing hospital practices.

Notes

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Select Committee on Aging. Hearing on elderly abuse: The hidden problem. U.S. House of Representatives, June 23, 1979.

Select Committee on Aging. Hearing on domestic violence against the elderly. U.S. House of Representatives, April 1980.

Appendix

A. Protocol for case assessment

B. Pretest for staff training

C. Audit form

D. Brochure: Elder Abuse Network

E. Brochure: Community Resources

Protocol for Elder Abuse and Neglect

Goal: Reduce incidence of elder abuse and neglect.

Purpose: Conduct medical history, psychosocial and physical exam to rule out elder abuse and neglect.

I. Medical History

A. Methodology/Technique:

1. Patient should be examined alone without caregiver.
2. Special attention should be given to trauma, burns, nutrition, medication and recent change in condition.
3. When possible, medication bottles or the pharmacy profile should be checked to be certain medications are being taken or given as prescribed.

B. Signs/Symptoms of Abuse or Neglect

1. Patient brought in by someone other than caregiver.
2. Prolonged interval between trauma/illness and presentation for medical care (i.e., gross decubiti).
3. Suspicious history: patient is new to system with history of "shopping" or "doctor hopping." Description of how injury occurred is alien to the physical findings; has injuries not mentioned in the history; has history of previous similar episodes; too may "unexplained" injuries or inconsistent explanations over time.

II. Psychosocial Evaluation:

A. Methods

1. Administer Goldfarb Dementia Scale (see attached).
2. Collect pertinent data:
   a. Finances, length of time at present residence, mode of transportation, who assists with transporting.
   b. Ability to do self-care, ambulation status, who assists with daily living needs: meal preparation, bill-paying, shopping.
   c. Amount of contact outside of residence--who and how often.
   d. Degree of patient's dependence on caregiver alone for financial, physical and/or emotional support.
3. Ask patient to describe a typical day.
4. Assess patient's role expectations of self and caregiver.
5. Have patient report recent crises in family life.
6. Ask if there is alcohol, drug use, or mental illness among family/caregiver(s).

7. Ask patient if s/he experiences difficulties of:
   a. Being shaken, shoved, hit (record where on body and frequency).
   b. Being left alone, tied to chair or bed, or left locked in room (record duration.
   c. Having money or property taken (specify).
   d. Not receiving food, medication or medical care, being oversedated with medication or alcohol.
   e. Being threatened, fearful of caregiver.
8. Assess how patient responds to stress and to incidents listed above.

III. Physical Exam

A. A standard comprehensive examination should be completed on a gowned undressed patient.

B. Diagnostic procedures as indicated by history or exam may include:
   1. Radiologic screen for fractures or evidence of physical restraint.
   2. Metabolic screen for nutritional, electrolyte, or endocrine abnormality.
   3. Toxicologic screen or drug levels for over-or-under-medication.
   4. Hematologic screen for coagulation defect when abnormal bleeding or bruising is documented.
   5. CAT for major change in neurological status or head trauma that could result in subdural hematoma.

C. If injury is due to an accident, document circumstances (i.e., patient was pushed, patient has balance problem, patient was drowsy from medications and fell).

D. Signs or symptoms of abuse/neglect

   1. Burns, especially unusual location or type.
   2. Bruises and hematomas.
      a. Bilaterally on upper arms as from holding and shaking.
      b. Clustered in the trunk as from repeated striking.
      c. Morphologically similar to an object.
      d. Presence of old and new bruises at the same time as from repeated injury.
      e. Presence of bruises after changing health care provider or after prolonged absence from health care agency.
   3. Neurological exam to document change in mental status from previous level and competence in managing own medication.
   4. Dehydration or malnourishment without illness-related cause.
   5. No new lesions during patient's hospitalization.
   6. Family/caregiver(s) do not visit or show concern.
   7. Abnormal/suspicious behavior of patient--extremely agitated, overly quiet or passive, or expresses fear of caregiver.
   8. You intuitively feel all is not well between patient and caregiver.

IV. Interview with caregiver

A. Interview the caregiver alone to obtain the following information:

1. Age and sources of income of caregiver.
2. Caregiver's responsibilities in and out of the home and contacts outside of home.
3. Caregiver's knowledge of patient's medical condition and necessary care and medications.
4. Caregiver's expectations of patient (realistic vs. unrealistic, i.e., may lack knowledge of "normal" process of aging).
5. Caregiver's expectations of own role.
6. Ask caregiver to describe typical day for him/herself.
7. Ask caregiver what are difficulties experienced in caring for patient.
8. Assess caregiver's physical and mental ability to withstand stress of caring for patient.
9. Assess support systems available to caregiver in caring for patient.

B. Signs of high-risk situation:

1. Alcohol, drug abuse, mental illness in caregiver's residence.
2. Caregiver is alienated, socially isolated, has poor self-image.
3. Caregiver is young, immature, and behavior indicates own dependency needs have not been met.
4. Caregiver is forced by circumstances to care for patient (i.e., has financial problems, is overworked), and patient is unwanted.
5. Caregiver had poor models; may have been abused by parents or guardians as children.
6. Caregiver's and/or patient's poor health or chronic illness may exacerbate poor relationship.
7. Caregiver exhibits abnormal behavior, e.g., overtly hostile or frustrated, secretive, shows little concern, demonstrates poor self-control, "blames" patient, exhibits exaggerated defensiveness and denial, lacks physical, facial or eye contact with patient, shows overconcern regarding correcting patient's bad behavior.
8. Caregiver's behavior response to above difficulties varies, i.e., "I try to humor her," or "I take his dinner away," or "I just try again."

C. Determine <u>indirectly</u> if caregiver:

1. Shoves, shakes, hits patient.
2. Leaves patient alone, tied to bed or chair, or locked in room.
3. Withholds food or medication.
4. Over-medicates.
5. Takes or misuses money or property.
6. Threatens patient with any of above or withholds necessary support or care.

CARE PLAN

1. Diagnostic Plan

   a. Appropriate care of patient by hospital team for presenting problems.
   b. Consider admission to hospital for short-term intervention for further assessment, education, and treatment.
   c. Home visit by RN from Medicare--certified home care agency to assess home situation and level of patient's functioning at home.

2. Educational plan

   a. Education/teaching of self-care to patient or appropriate care to caregiver.
   b. Inform caregiver of "normal" process of aging.

3. Therapeutic Plan

   a. Family counseling to clarify role expectations and reduce conflicts.
   b. Assist patient with alternate living arrangements, i.e., adult foster home, nursing home, other friends or relatives, shared housing, boarding home, medical.
   c. Legal intervention, i.e., guardianship proceedings.

4. Additional Resources Required

   Work with available agencies for support services, i.e., home visiting nurse, chorework services, meals-on-wheels, adult day care center, home health aide for personal care.

Materials adapted from protocol developed by Sue Tomita, MSW, and Vivian Williams, MSW, Harborview Medical Center, Seattle, Washington, 1981.

For additional information, contact Nancy Hooyman, Associate Professor, School of Social Work, University of Washington, Seattle, Washington.

GOLDFARB DEMENTIA SCALE:

Good (8-10) Fair (3-7) Poor (0-2)

Age _____

Day _____

Month _____

Year _____

Day of Birth _____

Year of Birth _____

Address _____

City _____

President _____

Past President _____

ELDERLY ABUSE QUESTIONNAIRE

Your cooperation in completing the following questionnaire is greatly appreciated. The personal information will not be used to identify anyone individually. Your effort will be helpful to us as we evaluate the usefulness of our training on elderly abuse. We appreciate your time and assistance.

INSTRUCTIONS

For each of the following questions, please select the appropriate answer. If you are not sure of the answer, please do not guess. Instead, circle the response "NS" for not sure.

1. An elderly victim is probably not being abused if:

NS T F a) There are no visible injuries.

NS T F b) S/he does not tell someone about it immediately.

NS T F c) S/he cannot consistently recount the accurate details about what happened.

2. The report by a woman over 75 about abuse should be doubted by service providers because:

NS T F a) She is confused and disoriented and thus unable to give an accurate description.

NS T F b) She may have provoked the abuse by her own behavior.

NS T F c) She has fantasies and makes up or exaggerates stories.

NS T F 3. Statistically, elderly men are as likely to be battered as elderly women.

NS T F 4. Emotional and psychological abuse can be as damaging as physical abuse.

NS T F 5. Most often, the abuser in instances of elderly abuse is not related by marriage or blood.

NS T F 6. Family violence is as common in white upper-class families as in Black, Native American, Asian, or Hispanic families.

7. Elderly abuse may consist of:

NS T F a) Shaving, shaking or hitting the patient

NS T F b) Tying the older person to a chair or leaving them alone for extended periods of time.

7. Elderly abuse may consist of: (continued)

NS T F c) Withholding food or medication.

NS T F d) Over-medicating.

NS T F e) Taking or misusing money or property.

NS T F f) Threatening the patient with any of the above or withholding necessary support or care.

8. Signs/symptoms of abuse or neglect are:

NS T F a) There is a prolonged interval between the trauma/illness and its presentation for medical care.

NS T F b) The patient has injuries not mentioned in the medical history or has "unexplained" injuries.

NS T F c) Dehydration or malnourishment exists without any illness-related cause.

NS T F d) There are burns of an unusual location or type.

NS T F 9. Alcohol and drugs are the cause of most battering.

NS T F 10. If an elderly person stays in a battering situation, it is because they think they deserve it.

NS T F 11. One explanation of elderly abuse is that battering is passed within a family from one generation to the next.

NS T F 12. Typically, the victim of elderly abuse lives alone and is quite isolated.

NS T F 13. Health care professionals in Washington are required by law to report all suspected incidents of elderly abuse.

NS T F 14. Under most circumstances, it is best for the victim to leave the abusive situation.

NS T F 15. When an elderly person seeks help, it is usually because they want to leave where they are living.

NH:10
2/82

2/19/82

SPECIAL STUDY FORM:
ELDER ABUSE/NEGLECT

Page ____ Of____

Time Frame _____

Period Covered _____

Selected by _____

1. Interviewer documented how presenting injury or illness occurred. (yes/no)
2. Interval between onset of injury and date of arrival to ER (# of days)
3. Toxicologic screen for drug levels indicate over-medication (yes/no/na)
4. Toxicologic screen for drug levels indicate under-medication (yes/no/na)
5. Documentation of dehydration without illness--related cause (yes/no/na)
6. Documentation of presence of old bruises or hematoma(s) (yes/no/)
7. Documentation of presence of new bruises or hematoma(s) (yes/no)
8. Documentation of discrepancy between statement of how injury occurred and physical findings (yes/no)
9. Documentation that injury presented to ER is of unknown etiology (yes/no)
10. Documentation that interviewer asked patient if being abused or neglected (yes/no/exception*)
11. Documentation that interviewer asked informant if patient being abused or neglected (yes/no/na)
12. Documentation of suspicion of elder abuse/neglect (yes/no)
13. Documentation of treatment plan for elder abuse-neglect
    a) yes; patient referred to ER Social Worker
    b) yes; patient referred to inpatient staff
    c) yes; patient referred to community agency
    d) yes; resource information and/or education provided
    e) other
    f) none

*Exception: Patient unable to respond

Ref No.	Medical Record No.	Patient's Name	Pt. Age	Sex M F	Service	Unit	1	2	3	4	5	6	7	8	9	10	11	12	13	Primary Diagnosis	Exception/Comments
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
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21																					
22																					

2/82

ANSWER KEY

ELDERLY ABUSE QUESTIONNAIRE

Your cooperation in completing the following questionnaire is greatly appreciated. The personal information will not be used to identify anyone individually. Your effort will be helpful to us as we evaluate the usefulness of our training on elderly abuse. We appreciate your time and assistance.

INSTRUCTIONS

For each of the following questions, please select the appropriate answer. If you are not sure of the answer, please do not guess. Instead, circle the response "NS" for not sure.

1. An elderly victim is probably not being abused if:

NS T (F) a) There are no visible injuries.

NS T (F) b) S/he does not tell someone about it immediately.

NS T (F) c) S/he cannot consistently recount the accurate details about what happened.

2. The report by a woman over 75 about abuse should be doubted by service providers because:

S T (F) a) She is confused and disoriented and thus unable to give an accurate description.

S T (F) b) She may have provoked the abuse by her own behavior.

S T (F) c) She has fantasies and makes up or exaggerates stories.

S T (F) 3. Statistically, elderly men are as likely to be battered as elderly women.

S (T) F 4. Emotional and psychological abuse can be as damaging as physical abuse.

S T (F) 5. Most often, the abuser in instances of elderly abuse is not related by marriage or blood.

S (T) F 6. Family violence is as common in white upper-class families as in Black, Native American, Asian, or Hispanic families.

7. Elderly abuse may consist of:

S (T) F a) Shaving, shaking or hitting the patient

S (T) F b) Tying the older person to a chair or leaving them alone for extended periods of time.

7. Elderly abuse may consist of: (continued)

NS (T) F c) Withholding food or medication.

NS (T) F d) Over-medicating.

NS (T) F e) Taking or misusing money or property.

NS (T) F f) Threatening the patient with any of the above or withholding necessary support or care.

8. Signs/symptoms of abuse or neglect are:

NS (T) F a) There is a prolonged interval between the trauma/illness and its presentation for medical care.

NS (T) F b) The patient has injuries not mentioned in the medical history or has "unexplained" injuries.

NS (T) F c) Dehydration or malnourishment exists without any illness-related cause.

NS (T) F d) There are burns of an unusual location or type.

NS T (F) 9. Alcohol and drugs are the cause of most battering.

NS T (F) 10. If an elderly person stays in a battering situation, it is because they think they deserve it.

NS (T) F 11. One explanation of elderly abuse is that battering is passed within a family from one generation to the next.

NS T (F) 12. Typically, the victim of elderly abuse lives alone and is quite isolated.

NS T (F) 13. Health care professionals in Washington are required by law to report all suspected incidents of elderly abuse.

NS T (F) 14. Under most circumstances, it is best for the victim to leave the abusive situation.

NS T (F) 15. When an elderly person seeks help, it is usually because they want to leave where they are living.

NH:10
2/82

SEATTLE-KING COUNTY

NETWORK ON ELDER ABUSE

The Seattle-King County Network on Elder Abuse is a group whose activities involve individuals, organizations, and agencies in a coordinated effort to deal with the problem of abuse of the elderly in Seattle-King County.

In referring to Elder Abuse, we include:

1. Abandonment - Leaving a vulnerable adult without the means or ability to obtain food, clothing, shelter, or health care.

2. Abuse - An act of physical or mental mistreatment or injury which harms or threatens a person through action or inaction by another individual.

3. Exploitation - The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

4. Neglect - A pattern of conduct resulting in deprivation of care necessary to maintain minimum physical and mental health.

Vulnerable adult refers to a person sixty years or age or older who has functional, mental, or physical inability to care for himself or herself.

Individuals or groups interested in obtaining more information about elderly abuse, should contact:

Sue Tomita, Harborview Medical Center, 223-5955, 223-3286 (message)

Nancy Hooyman, School of Social Work, U. of W, 545-1633

AGENCIES SERVING SENIORS

Adult Protective Services	464-7402 721-4294
Seattle--King County Division on Aging	625-4711
Outreach workers Seattle King County	 625-4969 854-6110
Geriatric Evaluation Team	322-0930

HEALTH SERVICES

Harborview Senior Care	223-4726
Pike Market Community Clinic	624-4134

LEGAL SERVICES

Senior Rights Assistance	623-2988
Senior Citizens Legal Service, Evergreen Legal Services	464-5911

HOME HEALTH SERVICES

Community Home Health Care	322-0930
Visiting Hurse Service	282-9800
Group Health Home Health Service	326-6080
Hill Haven Home Health	524-7145
Ballard Hospital Home Health Program	782-2700

TELEPHONE REASSURANCE

Providence Hospital Dial-A-Care	326-5711
Swedish Hospital Tele-Care	292-2121
Overlake Hospital Tele-Care	641-1511
Extended Services for the Elderly	392-2561
Kids on the Wheel	763-2227
Postal Alert	625-4834

CHORE SERVICES/HOMEMAKER SERVICES

DSHS--Chore and Homemaker Services
Denny (Capitol Hill Office) 464-7250
Bayview (Pioneer Sq. Off.) 464-7060

DAY CARE AND RESPITE CARE

Capitol Hill Adult Day Center	328-1974
Norwest Day Health Center	784-8285
University Adult Day Center	524-2321
Kline-Gallen and Adult Day Center	785-8800
Connection: South King County Respite Care	762-3421

NUTRITION PROGRAMS

Meals-on-Wheels	522-7666
Seattle/King County Nutrition Program for Elderly	525-8272
Mobile Market	522-7666
S.P.I.C.E. (Schools Programs Involving Our City's Elderly)	587-3524

ELDERLY ABUSE
AND NEGLECT

WHERE TO TURN...

If you are a victim of abuse or neglect...

If you suspect abuse is taking place...

If you know an elderly person being abused or neglected...

If you need help caring for an elderly family member...

EMERGENCY NUMBERS

Seattle Police	911
Seattle Crisis Clinic	447-3222

FOR GENERAL ASSISTANCE

Senior Information and Assistance	285-3110
Nursing Home Abuse Hot Line	1-800-562-6078

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